

CICRED'S SEMINAR

**Variation in the utilization of
Reproductive Health (RH)
Services and its determinants : an
empirical study in India**

S. Siva Raju

Variations in the Utilization of Reproductive Health (RH) Services and its Determinants: An Empirical Study in India*

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INTRODUCTION

Reproductive health is defined as a “state of complete physical, mental and social well being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and its function and process”. Reproductive health therefore is multi-dimensional and associated with various life cycle events of women such as menarche, marriage, pregnancy, childbirth and menopause. (Jayasree and Jayalakshmi, 2001). The main factors in the causation of reproductive health are poverty, lack of purchasing power, illiteracy, and malnutrition. They all contribute to the poor matrix of the mother who is to produce the future generation. The other factors which have a bearing on these are early age of marriage, large family size, high parity, small inter-pregnancy interval, burden to support family economy, ignorance and prejudices, social customs, non-availability of skilled health services at times of need, poor referral services and communication systems. (Venkateshwara Rao, 2001).

The Reproductive and Child Health intervention are expected to provide quality services and achieve multiple objectives. There has been a positive paradigm shift from Method-Mix Target based activity to client- centred-Demand Driven quality services. The Government of India re-oriented the programme and strengthen the services at out-reach level. The new approach requires decentralization of planning, monitoring and evaluation of the services at the basic nucleus level which is a district.

The Reproductive and Child Health (RCH) programme is basically a modification of the Child Survival and Safe Motherhood (CSSM) programme. It ensures the safety of women through pregnancy and childbirth by timely detection of maternal health problems and immediate medical attention. The maternal health care encompasses early registration of pregnancy, at least

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** Professor, Unit for Urban Studies, Tata Institute of Social Sciences, Deonar, Mumbai – 400 088, India.

three antenatal check-ups, universal coverage with T.T and IFA tablets, advice on adequate food and rest, early detection and referral of maternal complications, delivery by trained personnel, institutional deliveries for women with bad obstetric history and risk factors, management of obstetric emergencies, and birth spacing (Government of India, 1994).

HEALTH CARE SYSTEM IN INDIA

The health care system in India is operationalised on a three-tier system—the Central, State and the District. The responsibility of the Centre consists mainly of policy making, planning, guiding, assisting, evaluating and coordinating the work of the State Health Ministries. The responsibility for implementing the policies, however, rest with the state government which are required by the Constitution to provide medical and health care for people living in their jurisdictions. Actual implementation takes place at the district level, the district being the principal unit of administration in India. The office of the district medical and health officer serves as the nerve centre for integrating all state financed health activities in the rural areas. In urban areas health departments of municipalities are mainly responsible for providing preventive and curative health services.

A district is normally covered by 8 to 12 primary health centres. The medical officer incharge of a primary health centre has the overall responsibility for providing integrated health services, namely curative, preventive and promotive to the population, of about 80,000 to 1,0,000. Each primary health centre has sub-centres, which cater to a population of about 5,000. Each sub-centre, is manned by a male and female multipurpose health worker. They provide integrated package of services: medical care, maternal and child health care, family planning, control of malaria and other communicable diseases, environmental sanitation, collection of vital statistics and health education.

At the grass root level, there is a Village Health Guide for every 1000 population, and who is not a member of the conventional health service staff, but a selected representative of the community. By virtue of his situational factors, that is, nearness to the people, ability to establish rapport with them and so on, he acts as an instrument in developing motivation among the community members facilitating them to direct their energy and abilities to improve their own health status. Thus India's health system rests on a well conceived infrastructure to make health available to rural areas, the Village Health Guides sustaining it at the base, supported by multi-purpose health workers at the next layer, the sub-centre's staff at the next going up to the main primary health centres and their qualified personnel and finally, the government hospitals at the apex of the edifice.

POPULATION COVERAGE

At the all – India level 35 per cent of the women did not receive any ANC. Of the ANC services, 75 per cent of the women had received at least one TT injection but less than 50 per cent received IFA tablets and had abdominal check up; and for hardly one-third of the women BP and weight were recorded. Over one-third of the women had complications during pregnancy. While almost all women have knowledge of contraceptive methods, their usage is only by a half of them (RCH Project, 2000).

In the states of U. P., Bihar, M. P. and Rajasthan, utilization of Govt. health facilities for delivery was poor (5 – 16 per cent), whereas home deliveries were widely prevalent exceeding 75 per cent largely attended by untrained birth attendants (80 – 92 per cent), with greater probability for high risk of maternal morbidity and mortality. Post – delivery visits by female health workers were also the least in these states, where it was below 5 per cent. No immunization was reported for every second child in Bihar, every third child in Rajasthan and every fourth child in U.P. Poor performance regarding maternal and child health care and also family planning in these states is no wonder when they had a short fall of 13 – 28 per cent PHCs and 14 – 24 per cent sub-centres. Further, over one-fifth of the existing PHCs in U.P. and M.P. were running without any single medical officer. When the medical and health facilities in Govt. establishments are so poor in these states, it is quite natural for the rural folk to prefer home delivery seeking the services of untrained birth attendant etc. in the existing PHCs.

FACTORS INFLUENCING UTILIZATION OF HEALTH FACILITIES

The paradox is that, in spite of the availability of health facilities, their utilization is very meager- hardly 10 to 20 per cent (Griffith, 1963; John Hopkins University, 1976). The problem is more acute in the remote areas, where, whatever meagre facilities have been made available, they are not optimally utilized by the people. Instead, people go to practitioners of indigenous methods, who are not qualified, such as traditional birth attendants, faith healers and other private practitioners who live and work among them.

There are several studies that have been conducted on the utilization of existing health care services in India. (Griffith, 1963; Dutt et al 1975, Chuttani et al, 1976; John Hopkins University, 1976; Kakar, 1977; Ramachandran, 1977; Sharma et al, 1978; Queresho and Karbandam, 1980; Avasthi, 1980; Srikantan and Samuel, 1981; Seal, 1981; Jagadish, 1981; Kothari et al, 1982; Sivaraju, 1987; Yesudian, 1988). A majority of these studies have revealed the very poor image the government health centres have among the people. Some of the studies (John Hopkins University and Chuttanni) have indicated that only 10 to 20 per cent of the villagers utilize the government health services. Among the small proportion of villagers who used the facilities, a majority are

dissatisfied with the services, mainly because of the non-availability of medicines and the impersonal behaviour of the health functionaries.

According to Sharma et al (1979), the average time devoted to each patient by the medical officer at a government hospital was only 117.15 seconds. The medical officers, however, felt that they should spend at least 6.83 minutes for a patient. According to the authors, they are probably not able to do so because of long queues in the dispensaries during peak hours. Quereshi and Karbanda (1980), through observation of the activities of the medical officers in selected dispensaries during working hours, concluded that medical officers performed mainly two activities: history taking and prescription writing. With respect to the interaction between the district hospitals and primary health centres, Jagadish (1981) observed:

Doctors at the centres do not have opportunities to discuss with fellow professionals and specialists, the clinical problems peculiar to their area. There is no well organised referral system. Apart from the professional dissatisfaction, doctors complain about the facilities available in the rural areas- about the lack of proper accommodation, inadequate schooling for their children and unsatisfactory social life.

Similarly, Kothari et al (1982) observed that the unsatisfactory behaviour of the staff at the health centres, the long distance, the non-availability of drugs and lack of faith in doctor's treatment are some of the major factors responsible for the poor utilization of government hospital services. Siva Raju (1987) in his study on hospital utilization in Andhra Pradesh observed that the acceptability with respect to cleanliness and orderliness of the clinic, the time spent by the doctor to examine the client, the time spent by the client for waiting to see the doctor, privacy provided at the clinic, facility to rest and facility offered to accompanying person(s) were satisfactory only for less than half of the population. Yesudian (1988) pointed out the various factors responsible for the poor health status in metropolitan cities, despite large amount of resources being expended on health services. He concluded that so long as proper planning, organizing and distribution of services did not receive the attention of the authorities, there was no scope for any improvement in the situation.

A glance at Health and Family Welfare Programme statistics of India shows that there exist wide variations in the FPP performance among different states and among different regions within each state. This variation in performance is also noticed among different districts within the respective regions. Goyal, from his analysis of different states, concludes: "Some states with lower per capita expenditure on Family Welfare have achieved better coverage of population and consequently have shown better performance". Wide variations in the performance of Reproductive Health Programme, as noticed among different regions may be due to the differential levels of

development of the regions with respect to various socio-economic, demographic, cultural, ecological, health and other developmental factors.

Pisharoti found that neither socio-economic variables nor administrative resources variables individually account for major differentials of FP performance among different states in India. Their combined effect has been found statistically significant at the state level. Misra states that “the variations among different states in India regarding performance of family planning can be the result of: (a) the administrative and organizational machinery which can deliver the goods, (b) a composition of different client population, and (c) a combination of these two factors”. Further, he found that performance of FP is significantly correlated with variables, like percentage of literacy, per capita income, per capita electricity consumption, medical and paramedical personnel, expenditure on FP with the index of development. A state-wise analysis undertaken by the World Bank to study the relationship amongst programme inputs, socio-economic levels and FP performance in 15 states of India showed that the birth rate had significant correlation with death rate, urbanization, surfaced roads, and female secondary school enrolment. Yadav and Shah, in their study on two sets of districts in Karnataka state showing extreme performance of FP inferred that demographic variables, like per cent urban population, density of population, sex ratio and literacy rate, socio-economic and other developmental variables, like educational development, communication and recreational development, mechanization of agriculture, banking development, electrification, agricultural development, and programme input variables, like medical and FP service centres, staff position at PHC level and staff position at district level have all shown close association with FP acceptance rates. It is also observed that in the high performance districts, all the developmental variables mentioned above are uniformly important when compared with low performance districts. Srikantan, from his study of 15 states of India to find out the extent to which FPP output depends on the inputs and the infrastructure, inferred that though literacy, especially for females, is an important infrastructural indicator, facilitating programme implementation, female participation in the labour force has a direct effect on programme outputs. Malgavkar and Pai Panandiker, from their study, inferred that, “... the principal task should be to interlink and integrate immediately the delivery system in the specific socio-economic sectors with the FPP so that we can have better success in containing population growth and, simultaneously, in improving the quality of life of the Indian people. Siva Raju, from his study on regional differences in Andhra Pradesh, observed: “People in the Rayalseema and Telangana regions are characterized by low socio-economic status, high fertility level, more religious outlook, less modernity and low level of family planning adoption. On the other hand, the people in coastal Andhra have relatively better socio-economic status, less religiosity, more modernity, lower fertility level and higher level of Family Planning adoption”. From the review of these studies, it is very clear that there is a significant association between the level of development and the FP

performance among different states and regions of our country. Therefore, the study of spatial distribution and growth of population resulting from geographical, historical, economic, social and cultural factors is very important to understand the population problem of a region.

Despite the creation of a network of health care institutions, utilization of health services is limited, mainly because nearly three-fourths of the population prefer to take a quick recourse the age old habit of going to indigenous medical practitioners. A majority of the population, especially in rural areas prefer indigenous medicine, mostly, due to its advantages like, the culturally acceptability, low cost, and easy accessibility to the healer. Though they constitute a larger reserve of health manpower, their activities very seldom receive the attention of health officials. Emphasizing their importance, the report of the Alma Ata Conference states, "With the support of the formal health system, these indigenous practitioners can become important allies in organizing efforts to improve the health of the community".

Several studies have focused on various types of private practitioners and inter-relationships between traditional and modern systems of medicine (Alexander and Sivasamy, 1971; Pradhan, 1973; Bhatia et al, 1976; Mchinder, 1976; Kocher et al, 1976; Neumann et al, 1976; Kakar, 1977; Shukla et al, 1980; Gambhir and Udupa, 1981; Ramesh and Hyma, 1981; Sathyavathy, 1982).

It has been estimated that in India, traditional birth attendants deliver 50 to 60 per cent of the babies born (Bhatia, 1985). The traditional birth attendants lack knowledge regarding aseptic techniques of delivery and thus contribute for high infant and maternal mortality. To equip them to handle their jobs in a systematic and scientific manner, the Government of India has initiated training programmes to them and plans to train thousands of them, so as to have at least one trained traditional birth attendant in each village. The studies conducted in indigenous practitioners thus have clearly indicated their significant role in improving the health status of the people, especially in rural areas.

METHODOLOGY

In India, for women in reproductive age and those who stay in rural areas, getting proper medical aid was found to be beyond their reach, which is mainly due to their poverty, illiteracy, general backwardness and adherence to superstitious beliefs for suing illnesses and diseases. With a view to understand the variations in the utilization of Reproductive Health (RH) services and its determinants, an empirical study has been carried out in three contrasting states (Andhra Pradesh, Madhya Pradesh and Maharashtra) of India. Wide variations in the performance of reproductive health programme are noticed across these states (Table 1).

Table 1: Performance in Reproductive Health Programme in Selected States and India

	Maharashtra	Andhra Pradesh	Madhya Pradesh	India
Mothers receiving at least one ante natal check up	90.4	92.7	61.0	65.4
Deliveries in medical institutions	52.6	49.8	20.1	33.6
Age 12-23 months who have received all vaccinations	78.4	58.7	22.4	42.0
Percent of women/ their husbands ever used any method of contraception	61.7	57.3	49.6	51.3

Source: National Family Health Survey (NFHS-2), 1998-99, India, Key Findings, International Institute for Population Sciences.

Andhra Pradesh is the fifth largest state of India in terms of geography and population. Area wise the state has 2,75,068 sq. km. Population crossed 7.5 crores by March 2001. Density of population is 275 person per sq. km to date, which is significantly less than the national density of 324 persons. Majority of population are Hindus (59 millions). Andhra Pradesh has substantial population of schedule castes. The scheduled tribes form 6.3% of total population. In literacy too scheduled tribes are backward with meagre 17.0% of literates, while scheduled castes are slightly better with 32.0%. The urban population of the state in 2001 is 27.08% of total population, as compared to 26.89% in 1991 census. Andhra Pradesh's urban population is only marginally higher than the national level (25.7%) during previous census period. Andhra Pradesh occupies fifth position in the country consisting of 8.20% of urban population.

Maharashtra has a land area of 307,713 sq. km, which is about one tenth of the total land area of the country. As per 2001 census of India, the total population of the state is 96.8 million, which is 9.4 percent of the total population of India. In terms of population size, it is the second largest state in India next to UP. The population density of Maharashtra has increased from 257 persons per sq. km in 1991 to 314 persons per sq. km in 2001. 11 percent of Maharashtra's population belong to scheduled castes and 9 percent belong to scheduled tribes. Maharashtra is one of the urbanized states in India (42.0% urban) (Table 2).

Madhya Pradesh is located at the geographic centre of India. Spread over 443 thousand sq. kms. Madhya Pradesh is the largest Indian state in terms of area and accounts for 14 percent of India's land mass and 8 percent of India's population. The state has the highest proportion (23.0%) of scheduled tribes population in the country outside of the northeastern states. The variations in the levels of development and performance in reproductive health programmes were noticed among different districts within the states.

Table 2: Profile of Selected Districts

Characteristics	Nashik	Chittoor	Shivpuri
Population (in millions)	3.9 (79)	3.3 (67)	1.1 (66)
Density of population (per Sq. Kms)	248 (257)	215 (242)	110 (149)
Sex ratio (nos. of females/ 1000 males)	940 (934)	966 (972)	849 (931)
Literacy rate (in percentage):			
Persons	62.33 (64.87)	49.75 (44.08)	33.03 (44.20)
Males	73.98 (76.56)	62.61 (55.12)	47.50 (58.42)
Females	49.89 (52.32)	36.44 (32.72)	15.64 (28.85)
Percentage of urban population to total population	35.55 (38.69)	19.80 (26.89)	15.19 (23.18)

Note: Figures in Parentheses refer to States

Sources: (a) for Nashik: India : Registrar General of India (1991), District Census Handbook-Nashik

(b) for Chittoor: India : Registrar General of India (1991), District Census Handbook-Chittoor

(c) for Shivpuri: Data collected various offices of the districts of Shivpuri.

The sample survey approach was adopted in conducting the study. As the main focus of the study is to assess the existing patterns of health care system, with a special focus on Reproductive Health (RH), provided by the both government and non governmental health agencies, it was felt necessary to select the areas for the study in such away that all the governmental health programmes were implemented in those areas . Also to cover the study area from all the geographical regions of the country, Nashik district in Maharashtra (western part of India), Shivpuri district in Madhya Pradesh (northern part), and Chittoor District in Andhra Pradesh (southern part) were chosen. From each of there three selected districts, two primary health centres, one with very high performance and another with very low performance in reproductive health programme were selected. In each of the selected primary health centres, all the villages were listed out and ten from this list of villages were selected at random. In the selected villages, altogether 1087 currently married couples (less developed PHCs: 514; more developed PHCs:573) having at least

one child below 5 years of age were selected for the study. From each of the selected households, couples were considered as the respondents and they were contacted for data collection. An interview schedule, was administered to these couples and information related to reproductive health issues was obtained from them. Besides this, information from the private medical practitioners operating in the study areas and the local non-governmental organizations, was also obtained.

FINDINGS

Background of Respondents

The socio-economic and demographic background of the women are presented in terms of their educational status, occupational status and number of conceptions they had. Majority of the total sampled women are illiterate, without much variations across less and more developed areas. Over three fourths of them among both the areas are housewives. While 17.9 per cent of them in less developed area are daily wage earners, they constitute 16.6 per cent among the more developed areas. This indicates the poor living conditions of the people living in less developed areas when compared to those in more developed areas. Women in more developed areas have relatively lower fertility levels than those among the less developed areas. For instance, while nearly two-thirds (60.2%) of the women in more developed areas had 1 or 2 conceptions only, they constitute nearly a half (48.8%) among the less developed areas. The mean number of conceptions among the total sampled women is worked out to be 2.5, with variations across the areas (less developed areas: 2.6 and more developed areas: 2.3) (Table 3).

Table 3: Socio-economic and Demographic Background of Respondents

Socio-economic and demographic background	LDA (N=514)	MDA (N=573)	Total (N=1087)
(i) Educational status:			
Illiterate	50.8	64.2	57.9
Primary	13.6	9.7	10.5
Secondary	31.1	25.3	28.1
Collegiate	4.5	2.8	3.6
(ii) Occupational status:			
Housewives	73.3	79.4	76.5
Daily wage earner	17.9	16.6	17.2
Others	8.8	4.0	6.3
(iii) Number of Conceptions			
1	30.9	40.8	36.2
2	17.9	19.4	18.7
3	23.9	17.1	20.3
4	14.4	11.2	12.7
5	12.8	11.5	12.1
Mean	2.6	2.3	2.5

Note: LDA= Less Developed Area
MDA= More Developed Area

Ante Natal Care

Ante natal aspects such as, visit by health worker, from which month of pregnancy on wards they visited, total number of visits they made, proportion of women received any service from the workers, periodical medical check-up, and Tetanus toxoid taken, are covered in the study. Over two thirds (67.9%) of women in the more developed areas as against 53.9 per cent of them in less developed areas have stated that health worker of their area had visited them during their pregnancy. Their visits to them are largely during 4-6 months of pregnancy. The total number of visits made by the health workers are more

(Mean: 2.3 years) in more developed areas than those in the less developed areas (Mean: 1.7 years) (Table 4). The proportion of women who received iron & folic acid tablets from the field health staff is also very high (65.3%) among the women in the more developed areas than those belonging to the less developed areas. Similarly, consultations made for periodical medical check ups also revealed wide differences among the women belonging to the two contrasting areas, under study.

Table 4: Utilization of Ante Natal Care Services

Ante Natal Care Services	LDA (N=514)	MDA (N=573)	Total (N=1087)
(i) Did anybody visit your house			
NA	43.4	29.0	35.8
No	2.7	3.1	2.9
Yes	53.9	67.9	61.3
(ii) Visited from which month onwards			
N. A	46.1	32.1	38.0
1-3 month	15.4	15.7	16.3
4- 6 month	30.3	39.5	35.1
7+ month	7.2	9.4	8.4
When pregnancy known	1.0	3.3	2.2
Mean	6.4	6.0	6.4
(iii) Average number of visits up to the time of delivery			
Mean	1.7	2.3	2.5
(iv) Proportion of women who received iron and folic tablets			
Yes	46.9	65.3	56.5
(v) Consulted for periodical medical check-up			
N.A	45.7	30.5	37.7
No	9.3	23.9	17.0
Yes	44.9	45.5	45.3
(vi) From which month onwards consulted			
Mean	4.7	3.7	4.1

Note: LDA= Less Developed Area
MDA= More Developed Area

Natal Care

Home deliveries are widely reported by women in the study, without much variations across the areas. The findings clearly reveal the importance of traditional birth attendants, especially during delivery. It is significant to note that a quarter (25.9%) of the women belonging to less developed areas have developed pregnancy complications during delivery which clearly indicate the traditional delivery practices adopted in the community. Their corresponding proportion among the women of more developed areas was to the extent of 21.5 per cent. Over one fifth of them (21.6%) in the less developed areas have consulted field health workers regarding their pregnancy complications (Table 5).

Table 5: Utilization of Natal Care Services

Natal Care Services	LDA (N=514)	MDA (N=573)	Total (N=1087)
(i) Place of Delivery			
Home	81.5	89	85.5
Hospital	18.5	11.0	14.5
(ii) Any pregnancy complications			
No	74.1	78.5	76.4
Yes	25.9	21.5	23.6
(iii) Consulted for pregnancy complications			
No	78.5	80.3	79.4
Yes	21.6	19.7	20.6

Note: LDA= Less Developed Area
MDA= More Developed Area

Post Natal Care

Nearly one third of sampled women, among both the less and more developed areas, have stated that they consulted health personnel within one month after delivery. Further, it is observed that childcare was relatively better provided in more developed regions by the health personnel as compared to that in the less developed areas. For instance, while nearly a half (45.5%) of the women in more developed areas have received Vitamin A solution for their new born child, they constituted only 29.6 per cent in the case of those belonging to less developed areas. Similarly, in the case of vaccination of their newborn child, it is noticed that while two thirds of the women from the more developed areas (64.6%) have vaccinated, their corresponding proportion in the less developed areas is only 52.9 per cent (Table 6). Thus, it is observed that the facility for postnatal care is relatively at the higher level in the more developed regions as compared to the less developed areas.

Table 6: Post-Natal Care Services

Post- Natal Care Services	LDA (N=514)	MDA (N=573)	Total (N=1087)
(i) Within one month after delivery, consulted any health personnel			
N. A	46.9	32.3	39.2
Not consulted	21.6	36.1	29.3
Consulted	31.5	31.6	31.6
(ii) Vitamin A solution for new born child			
Not received	70.4	54.4	62.0
Received	29.6	45.5	38.0
(iii) Vaccination to new born child			
Not vaccinated	47.1	35.4	40.9
Vaccinated	52.9	64.6	59.1

Note: LDA= Less Developed Area
MDA= More Developed Area

Family Planning- knowledge, attitude and practice

For a country like India, adoption of small family size norm is very essential and in this regard, family planning programme initiated by the Government of India as early as in 1952 play a vital role. There exist wide differences in the levels of knowledge, attitudes and practice of contraception in the community and much variations are found to be significantly varying across various regions in the country. The present study also concurs with the earlier studies in the case of level of knowledge of family planning programme. Except 4 per cent of the respondents, almost all of them have heard of family planning programme. With regard to their attitude towards the programme, and overwhelming proportion of them (81.8%), without much variation across the less and more developed areas, have appreciated the programme. However, the actual practice level among them is reported to be significantly vary across the two contrasting areas. For instance, while the proportion of those who have ever used any method of family planning is reported to be 54.3 per cent among the more developed areas, their proportion has come down to 25.5 per cent in the case of the less developed areas. Such a wide variations across the areas clearly reflects on the existing variations in the health infrastructural facilities, level of development and other factors, besides the socio-economic, demographic, health and cultural background of the community members.

In the case of post adoption services also, the data reveal that the health personnel's involvement is very low (19.3%) among the women of the less developed areas as compared to 21.1 per cent of them reported from the more developed areas (Table 7). This confirms that relatively better follow up services for the adopters of contraception prevailing in more developed areas as against that in the less developed areas might be a factor for the better performance of family planning adoption in the former areas.

Table 7: Family Planning- Awareness, Attitude and Practice

Family Planning Programme Performance	LDA (N=514)	MDA (N=573)	Total (N=1087)
(i) Awareness about family planning			
Not aware	4.7	3.7	4.1
Aware	95.3	96.3	95.9
(ii) Feeling about those who adopted contraception			
Depreciate	1.9	1.0	1.5
Appreciate	82.3	81.3	81.8
Uncertain	15.8	17.6	16.7
(iii) Ever used any method of family planning			
No	74.5	45.7	59.3
Yes	25.5	54.3	40.7
(iv) Health personnel provided post adoption services			
No	80.7	78.9	79.8
Yes	19.3	21.1	20.2

Note: LDA= Less Developed Area
MDA= More Developed Area

Utilization of Health Services

Utilization of health services plays an important role in improving the population coverage for Reproductive Health Programme. In this regard, the type of health centre the community member visiting during their ill health, the

level of satisfaction about health service facilities are some of the major issues which helps in assessing their acceptability of various health services. The utilization of various health centres like government hospitals, primary health centres, sub centres located in the area are more by the women from the more developed areas (30.4%) as against only 7 per cent in the case of those from the less developed areas. In contrast, the utilization of only primary health centre is mostly (53.1%) by the women from the less developed areas when compared to 21.6 per cent of them from the more developed areas (Table 8). The utilization of sub centre which is a local level health unit, is significantly higher among those from the more developed areas which reveals the acceptability and accessibility of the local level sub centre in these areas when compared to only 16.9 per cent of them in the less developed areas.

The data on the level of satisfaction with the utilization of health service facilities indicate that an overwhelming proportion (84.6%) of the women from the more developed areas when compared one third (37.4%) from those of the less developed areas are fully satisfied with the existing health services.

An attempt is also made in the study to assess the health service acceptability of the respondents in terms of various facilities viz, location of the clinic, cleanliness and orderliness of the clinic, comfortableness of waiting room, waiting time before seeing the doctor, time spent by the doctor with the patient, facilities existing around the clinic, and satisfaction with referral facilities. The data on all the indicators of service acceptability show that the respondents level of satisfaction with respect to these indicators are relatively higher in the less developed areas when compared to their counterparts in the more developed areas. The findings indicate that in view of the higher level of utilization of these facilities and also of the availability of alternative health system like, private hospital and other health centres, the respondents belonging to the more developed areas have stated a greater level of satisfaction with the facilities available at the government health centres. On the contrary, in the absence of other alternative health systems and also of utilizing the locally available indigenous systems, women from the less developed areas have expressed their greater satisfaction with the facilities available at the government health centres. The dissatisfaction of the clients would incline them only not to attach importance to the advice of the health personnel working at these government health centres. Therefore, increasing the credibility of the service personnel and also to increase the influence of these persons among the clients for motivating them to accept and utilize various Reproductive Health Programmes, better amenities may have to be urgently provided at these centres.

Table 8: Health Service Acceptability

Health Service Acceptability	LDA (N=514)	MDA (N=573)	Total (N=1087)
(i) Type of health centre visited			
Not applicable	13.8	3.0	8.1
Sub centre	16.9	37.3	27.7
PHC	53.1	21.6	36.5
Government hospital/dispensary/private doctor	8.8	7.7	8.2
Sub centre & PHC/ Govt. hospital	7.4	30.4	19.5
(ii) Feeling about health service facilities			
Not satisfied	25.5	4.2	14.3
Partly satisfied	37.2	9.4	22.5
Fully satisfied	37.4	86.4	63.2
(iii) Proportion of those who are with PHC not satisfied			
Location of the clinic	11.1	24.6	18.2
Cleanliness and orderliness of the clinic	17.9	21.3	19.7
Comfortableness of waiting room	22.0	26.0	24.1
Waiting time before seeing the doctor	30.9	21.5	25.9
Time spent by the doctor with the patient	21.0	24.8	23.0
Facilities existing around the clinic, like shopping centres, medical shops, hotels etc.	14.4	23.7	19.3
Satisfaction with referral facilities	14.2	30.0	22.5

Note: LDA= Less Developed Area
MDA= More Developed Area

CONCLUSIONS AND RECOMMENDATIONS

A vast country, like India, with very wide disparities in various sectors of development among different states, uniform strategies for the country as a whole will not yield the desired results. As the reproductive health programme is a source of strength to all other schemes of socio-economic development, effective measures have to be initiated to improve its performance among all states. Therefore, there is a necessity for formulating policies and programmes on realistic estimates and parameters and more meaningfully in a decentralized manner for effective promotion of the programme in all regions. Identification of regions and broad cultural groups within each region on the basis of their performance in health programme has to be initiated. It would provide clues to the health personnel to channelize their effects on a realistic and differential basis among the regions and cultural groups, wherever performance of health programme varies.

In conclusion, it is observed that the number and types of variables and their extent of influence on reproductive health programmes across different cultural and regional groups significantly vary. Further, there are certain common specific factors that influence reproductive health status of the people belonging to different in the cultures and regions. Hence, these findings raise a number of issues for formulating policies in the field of reproductive health, not uniformly for the country as a whole, but differentially for sub-regions in various parts of the country. Similarly, the pattern of various in-puts for developing the reproductive health programme may also have to be suitably modified in view of the diversity of the factors and their influence on health care programmes across different cultures and ecological regions. Thus, the findings are unique in many aspects and should have far-reaching, theoretical, methodological, policy and programme implications in the reproductive health care programmes. Some of the most important implications of the present study are given below:

1. The findings of this research would suggest the need for a change in methodology for studies on Reproductive Health Programmes. As differences exist in the performance in health programmes in different regions and cultural groups, it is essential to study the various determinants by stratifying the population according to regions, communities and other stratification variables. This would be a methodological achievement for improving explanatory efforts to understand better, the determinants of reproductive health status of women among different regions and groups.
2. Identification of areas and broad cultural groups within each area on the basis of their performance in RCH programme would provide clues to the health personnel to channalise their efforts on a realistic and differential basis among the regions and cultural groups, wherever performance in various health programmes varies.
3. Lack of proper infrastructural health facilities in the less developed, areas rightly indicates the urgency of increasing infrastructural and

health services and doctor-patient ratio in these areas. Hence differential financial and other inputs may have to be provided for different areas on the basis of their requirements and the existing performance in various health programmes in general and reproductive health programmes in particular.

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